

SUGGESTED DOCTOR'S APPROVAL FORM

Tai Chi for Diabetes Program

Doctor's Name:

Address:

Postcode: Telephone: Fax:

Thank you for providing the following information about your patient who wishes to join the Tai Chi for Diabetes Program. All information is strictly confidential and will only be available to class leaders. This information is used to provide instructors with accurate information case of emergency, and for appropriate exercise selection.

Type of diabetes:

●Area of special care:

Does this patient require an assessment by a dietitian prior to entering the *Tai Chi for Diabetes* program? Yes No

Are there any type of exercises which should be avoided? Yes No

If Yes, name these exercises:

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Is there any other relevant information which might affect treatment in an emergency situation?

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I advise that is medically fit to participate in the *Tai Chi for Diabetes* program. I have read the "Program Information" sheet (see other side).

Doctor's Signature: Date: